20

20 Independent Laboratory

Laboratory services are professional and technical laboratory services in one of the following four categories. Independent lab services are:

- Ordered, provided by, or under the direction of a provider within the scope of their practice as defined by state law
- Ordered by a physician but provided by a referral laboratory
- Provided in an office or similar facility other than a hospital outpatient department or clinic
- Provided by a laboratory that meets the requirements for participation in Medicare

The policy provisions for Independent Laboratory providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 9.

20.1 Enrollment

EDS enrolls Independent Laboratory providers and issues provider contracts to applicants who meet the licensure and certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an independent laboratory is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursement for laboratory-related claims.

NOTE:
All nine digits are required when filing a claim.

Independent laboratory providers are assigned a provider type of 09 (Independent Laboratory). The valid specialties for Independent Lab providers include the following:

- Independent Lab (69)
- Department of Public Health Lab (L3)

NOTE:

Independent Laboratories assigned specialty L3 should refer to Chapter 9, County Health Department, in the *Alabama Medicaid Provider Manual* for State Agencies.

Enrollment Policy for Independent Laboratories

To participate in the Alabama Medicaid Program, Independent Laboratories must meet the following requirements:

- Possess certification as a Medicare provider
- Possess certification as a valid CLIA provider if a clinical lab
- Exist independently of any hospital, clinic, or physician's office
- Possess licensure in the state where located, when it is required by that state

20.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

20.2.1 Covered Services

Medicaid reimburses Independent Labs for services described by procedures that fall between ranges 80049-89399 in the CPT manual. Medicaid also pays for procedures defined in the locally assigned Healthcare Common Procedural Coding System (HCPCS) to supplement the listing in the CPT manual.

Medicaid only pays Independent Lab providers for covered services which they are certified to perform and which they actually perform.

Independent Lab providers may only bill for routine venipuncture for collection of laboratory specimens when sending blood specimens to another site for analysis. Labs may not bill the collection fee if the lab work and specimen collection is performed at the same site. Labs may not bill the collection fee if they perform analysis in a lab owned, operated, or financially associated with the site in which the specimen was drawn.

20.2.2 Non-Covered Services

Medicaid does not pay packing and handling charges for referred laboratory services.

The referred laboratory receives payment for referred tests only at the normal rate. Medicaid shall monitor this policy through post-payment review.

20.2.3 Clinical Laboratory Improvement Amendments (CLIA)

All laboratory testing sites providing services to Medicaid recipients, either directly by provider, or through contract, must be CLIA certified to provide the level of complexity testing required. The Independent Lab must adhere to all CLIA regulations. As regulations change, Independent Labs must modify practices to comply with the changes. Providers are responsible for providing Medicaid waiver or certification numbers as applicable.

Laboratories which do not meet CLIA certification standards are not eligible to provide services to Medicaid recipients or to participate in Medicaid.

NOTE:

The Health Care Financing Administration (HCFA), now known as CMS, implemented the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88), effective for dates of service on or after September 1, 1992. The CLIA regulations were published in the February 28, 1992 Federal Register. More detailed information regarding CLIA can be found at http://www.cms.hhs.gov/clia/

CLIA Certificates

CLIA certificates may limit the holder to performing only certain tests. Medicaid bills must accurately reflect those services authorized by the CLIA program and no other procedures. There are two types of certificates that limit holders to only certain test procedures:

- Waiver certificates – Level 2 certification
- Provider Performed Microscopy Procedure (PPMP) certificates – Level 4 certification

A complete listing of laboratory procedures limited to waived certificates (level 2 certification) and PPMP certificates (level 4 certification) may be accessed via the web at www.cms.hhs.gov/clia/.

Added: A complete listing…at www.cms.hhs.gov/clia/.

Deleted: ~~The following sections… labs may perform.~~

Deleted: ~~Waiver Certificate-Level 2 Certification section~~

20.3 Prior Authorization and Referral Requirements

Laboratory procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

Deleted: ~~Provider Performed Microscopy Procedure (PPMP)~~

20.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided for laboratory services.

20.5 Completing the Claim Form

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Independent Laboratory providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

20.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Independent Laboratory providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

20.5.2 Diagnosis Codes

Claims for lab services must contain a valid diagnosis code. The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

20.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Medicaid denies claims without procedure codes or with codes that are invalid.

Medicaid also recognizes modifiers when applicable. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following sections describe procedure codes and modifiers that apply when filing claims for independent lab services.

Repeat Laboratory Procedures

Modifier '91' may be utilized to indicate that a laboratory test was performed multiple times on the same date of service for the same recipient. Modifier '91' may not be used when laboratory tests are rerun:

- To confirm initial results
- Due to testing problems encountered with specimens or equipment
- For any other reason when a normal, one-time, reportable result is all that is required.

Distinct Procedural Service

Modifier '59' (distinct procedural service) may be utilized to identify a distinct service. When laboratory services are performed, modifier '59' should be used to report procedures that are distinct or independent, such as performing the same procedure (which uses the same procedure code) for a different specimen. Modifier '59' should not be used when a more descriptive modifier is available.

Blood Specimens

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Independent laboratory providers will not be paid for and should not submit claims for laboratory work done for them by other independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own laboratory facilities.

Providers who send specimens to another independent laboratory for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

Laboratory Paneling and Unbundling

A *panel* is a group of tests performed together or in combination. Medicaid follows the CPT guidelines for panel tests.

The term "unbundling" refers to the practice of using more than one procedure code to bill for a procedure that can more appropriately be described using fewer codes. The use of unbundled codes results in denial of payment, with the exception of organ and disease panels.

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Added: is

All organ and disease oriented panels must include the tests listed with no substitutions. If only part of the tests included in a defined panel is performed, the panel code should not be reported. If additional tests to those indicated in a panel are performed, those tests should be reported separately in addition to the panel code. If two panels overlap, the physician or laboratory will be required to unbundle one of the panels and bill only for the tests that are not duplicative.

Added: and

Hematology - Claims for the same recipient from the same provider for the same date of service that contains two or more of the following services (85021, 85022, 85023, 85024, 85025, and 85027) will be considered an unbundled service and will be denied.

- Procedure codes 85022 and 85023 billed on the same date of service as 85077 (platelet count manual differential) will be denied
- Procedure codes 85023, 85024, 85025, and 85027 billed on the same date of service as 85590 (manual count) and 85595 (automated count) will be denied
- Procedure codes 85021 through 85027 billed on the same date of service as 85041 (red blood cell only), 85048 (white blood cell only), 85018 (hemoglobin only), or 85014 (other than spun hematocrit) will be denied

Added: and

Urinalysis – Claims for the same recipient billed by the same provider that contain two or more of the following services (81000, 81001, 81002, 81003, 81005, 81007, 81015, and 81020) for the same date of service will be considered an unbundled service and will be denied.

Deleted: ~~NOTE~~

During post-payment review, Medicaid may recoup payment from providers for claims submitted containing unbundling of laboratory services.

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Modifiers

Modifier	***HCPCS-Modifier(s)***	***Description***	***Note***
26	26	Professional Component	Labs providing professional component services include modifier 26 with the procedure code on the claim

Modifier	*HCPCS-Modifier(s)*	*Description*	*Note*
59	59	Distinct Procedural Service	To indicate a distinct procedure (using the same procedure code) performed on the same date of service.
77	77	Repeat Procedure by another physician	To indicate that a basic procedure performed by another physician had to be repeated
91	91	Repeat Clinical Diagnostic laboratory Test	To indicate a repeat clinical laboratory test performed on the same date of service for the same recipient.
TC	TC	Technical Component	

Added: Modifier 59

Deleted: ~~Modifier GB, Y2 to Y9, Z2 to Z3~~

NOTE:

Claims submitted for a repeat of the same procedure on the same date of service without modifiers will be denied as duplicate services.

Professional and Technical Components

Some procedure codes in the 70000, 80000, 90000, and G series are a combination of a professional component and a technical component. Therefore, these codes may be billed three different ways; (1) as a global, (2) as a professional component, or (3) as a technical component.

- **Global**, the provider must own the equipment, pay the technician, review the results, and provide a written report of the findings. The procedure code is billed with no modifiers.
- **Professional component**, the provider does not own the equipment. The provider operates the equipment and/or reviews the results, and provides a written report of the findings. The professional component is billed by adding modifier 26 to the procedure code.
- **Technical component**, the provider must own the equipment, but does not review and document the results. The technical component charges are the facility's charges and are not billed separately by physicians. The technical component is billed by adding modifier TC to the procedure code.

20.5.4 Place of Service Codes

The only valid Place of Service Codes for Independent Laboratory providers is 81.

POS Code	*Description*
81	Independent Laboratory

20.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

NOTE:
When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.9, Required Attachments, for more information on attachments.

20.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N